Creating Trauma-Informed & Developmentally Appropriate Systems of Care in Child Abuse and Neglect Prevention

Guiding Principles of Practice

Scientists and researchers in the last several decades have made great strides in understanding the impact of trauma on the developing brain. Early experiences, whether adverse or positive, have a profound impact on lifelong well-being. The Adverse Childhood Experiences (ACE) study, conducted in 1995-1997 was the first to correlate early adverse experiences with adult physical and mental health outcomes. ACEs have been linked to higher rates of smoking, alcohol use, chronic disease, mental illness and early death.[1]

In Wisconsin, according to findings from the 2010 Behavioral Risk Factor Survey, 56% of adults reported having at least one ACE and 14% reported four or more. These adverse experiences relate to poorer mental and physical health outcomes, greater participation in health risk behaviors, lower socioeconomic and educational outcomes, greater reliance on public health benefits, like Medicaid, and an overall lower quality of life.[2]

In addition, over the last two decades, advocates and consumers have led efforts to integrate trauma-informed care principles into traditional service delivery systems. In particular, attempts have been made to make the systems more consumer-friendly and ensure staff have a greater understanding of the role of trauma in clients' lives. With the recent Wisconsin ACE findings clearly showing that a majority of Wisconsin adults have experienced trauma in their lives, it's even more imperative that all of our social services systems, including prevention programs are adequately prepared to assist individuals with trauma histories.

According to Roger Fallot[3] and Maxine Harris[4], two leading experts in the field of trauma, "human service systems become trauma-informed by thoroughly incorporating, in all aspects of service delivery, an understanding of the prevalence and impact of trauma and the complex paths to healing and recovery." In addition, Fallot and Harris identify trauma-informed services as those designed specifically to avoid re-traumatizing individuals who seek assistance from our agencies.[5]

1. Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., et at. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. American Journal of Preventive Medicine, 14. 245-258.
2. O'Connor, C., Finkbiner, C., & Watson, L. (2012). Adverse Childhood Experiences in Wisconsin: Findings from the 2010 Behavioral Risk Factor Survey. Madison, WI: Children's Trust Fund and Child Abuse Prevention Fund of Children's Hospital.
3. Roger Fallot, Ph.D. is a clinical psychologist and Director of Research and Evaluation at Community Connections, a private, not-for-profit mental health agency in Washington, DC. Fallot's professional areas of specialization include the development and evaluation of services for trauma survivors.
4. Maxine Harris, Ph.D. is CEO and Co-Founder of Community Connections. She is also the Executive Director of the National Capital Center for Trauma Recovery and Empowerment. In the past several years, Community Connections has specialized in gender-specific approaches to treating women and men, trauma survivors, homeless persons, and substance abusers.
5. Harris, M. and Fallot, R. (Eds.) (2001). Using Trauma Theory to Design Service Systems. New Directions for Mental Health Services. San Francisco: Jossey-Bass.

Researchers and experts involved in trauma-informed care work also use the term developmentally appropriate services when describing trauma-informed services. The following definitions guided the creation of this document.

Trauma-informed services *are designed to provide services in a manner that is welcoming and appropriate for all, including individuals and families who have experienced trauma. The services do not treat symptoms related to adverse experiences including sexual abuse, physical abuse, and witnessing violence. Rather, regardless of their primary mission – to deliver education, health and behavioral health care or provide housing supports or employment counseling, for example – their commitment is to adopt a universal approach to trauma.*[6]

Developmentally appropriate services *consider the physical, social, emotional, and intellectual development of each child in all aspects of service delivery and understand both universal age appropriateness – predictable sequences of growth in children (ex. children walk before they run) and individual age appropriateness-the unique sequence of growth of each child which takes into account the personality, learning style and background and culture of each child (ex. one child learns to walk at 10 months of age, another learns to walk at 14 months of age).*[7]

The following trauma-informed guiding principles were designed to help move the child maltreatment prevention field in Wisconsin towards a more trauma-informed culture and service delivery system that empowers and heals, rather than marginalizes or harms further. Though these principles were created for the child maltreatment prevention field, it is our hope and intent that they will be used widely throughout the state in a variety of fields that serve Wisconsin citizens. We encourage all agencies and organizations to take advantage of our work and adapt these principles to your fields of service.

Embracing the principles of practice requires participation by all levels of the organization from the Board of Directors through direct service staff so that they are integrated in all facets of the agency. Decisions about resource allocation should be made through the lens of these principles. In addition, people with lived experiences of trauma who have also received services from the organization should be involved in all levels of the organization to ensure the agency is truly responsive to the needs of consumer.

For each of the principles, examples are given to guide the work of direct services staff and organizational leaders/ management in transforming the agency to a trauma-informed culture. A companion document, Trauma-Informed Organizational Self-Assessment for Child Abuse Prevention Agencies is also available. Each core value statement encompasses sections or points from the Organizational Self-Assessment. For a comprehensive cross-walk between the two documents, please refer to the end of this document.

6. Maxine Harris and Roger Fallot, 2001.
7. National Association of Educators of Young Children, n.d.

1. Understand the prevalence and impact of trauma through ongoing education and training.

Direct Service Staff
D1. All staff should have a basic understanding of the consequences and symptoms of complex trauma and what drives certain behaviors in individuals who have experienced trauma, including certain triggers and coping strategies.
D2. Develop basic trauma-informed care training for all newly hired staff that includes self-care, boundaries, and compassion fatigue.
D3. Develop agency train-the-trainers model for sustaining trauma-informed education.

Supervisors/Managers/Agency Leaders
S1. Integrate mastery of trauma-informed care skills into hiring process and staff evaluations.
S2. Staff trainings at all levels should incorporate information on the impact and prevalence of trauma.
S3. Designate one or more staff as trauma-informed care champions to serve as internal consultants on the issue of trauma for the agency.
S4. Incorporate metrics for “relational” staff behavior into performance evaluations.
S5. Review critical incidences through the lens of growth and learning versus blame and punishment.
S6. Raise trauma topics during staff supervision; offer enhanced supervision for staff who is working closely with individuals who have severe trauma histories.
S7. Identify and problem-solve staff’s concerns regarding trauma-informed care transformation.
S8. Maintain an ongoing trauma-informed care work group that includes individuals who have received agency services, as well as staff from all levels of the agency.
S9. Consult with administrators from other agencies who have made trauma-informed care changes.
S10. Provide ethics and boundaries training annually to all staff.
S11. Train all agency leaders, supervisors and managers at least every two years on trauma-informed care topics and supervision techniques.

2. Promote effective collaboration across systems and disciplines.

Direct Service Staff
D1. All staff should have a depth of understanding about prevention, early intervention and treatment systems and have the personal relationships with key staff in those systems to appropriately refer individuals in need of services.

Supervisors/Managers/Agency Leaders
S1. Host lunch and learns with agency staff and invite key stakeholders from multiple sectors to share about their work/services.
S2. Invite providers and community partners to help frame and resolve issues. Be transparent in goals, parameters and expectations.

3. Utilize evidence-based practices and support promising practices.

Direct Service Staff
D1. Practice fidelity to evidence-based program models.
D2. Incorporate one or more trauma-specific interventions into work with participants.
D3. Incorporate sensory modulation options into programming.

Supervisors/Managers/Agency Leaders
S1. Models of service delivery and program materials should have a robust evaluation component and should be based on existing evidence in the literature.
S2. Support promising practices and evaluate effectiveness.

4. Promote trauma screening, assessment and referrals to community resources.

Direct Service
D1. Implement universal trauma screenings and assessments.
D2. Individuals being referred to community resources should be given the name of an individual that they can contact.

Supervisors/Managers/Agency Leaders
S1. Build internal capacity to provide appropriate referrals to community resources.
S2. Provide leadership in the community on trauma-informed services by sharing the agencies' examples and educating others on how to become trauma-informed.

5. Promote physical and emotional safety.

Direct Service
D1. Pay attention to an individual's verbal and non-verbal cues and modify interactions to maintain a calm and safe environment for all.
D2. Provide confidential places for individuals to communicate.
D3. Allow advocates to assist individuals that are receiving services from your agency.
D4. Make sure that every individual seeking services from the agency has a "safety/de-escalation plan."
D5. Inform participants how the agency responds to personal crisis.
D6. Every adult and child in the program has a written crisis prevention plan.
D7. Provide safe, monitored areas for children to play.

Supervisors/Managers/Agency Leaders
S1. Perform an environmental survey to assess safety and healing aspects of the agency environment.
S2. Assess building location for safety and accessibility.
S3. Remove designated staff/participant bathrooms.
S4. Use sound reducing techniques (white noise machines, carpeting)
S5. Create a reception area that is welcoming, clean, safe and quiet.
S6. Post consumer rights posters in a visible area and regularly review rules and grievance procedures.
S7. Develop forums/structures for all staff to talk about vicarious trauma.

6. Build trust through honesty and transparency.

Direct Service
D1. Establish open dialogue; foreshadow events; take time to explain and answer questions. Share concerns with the family; Problem solve together, Model honesty and transparency.
D2. Thoroughly explain agency, types of services offered, and how services are delivered. Take time to walk families through the process, answer questions and address any concerns. Explain the use of forms (intake, confidentiality) and how they are used. Explain the mandated reporter law and your responsibilities under the law.
D3. Explain the use of screening and assessment instruments; share the results, explain what they mean, and how they will be used. Create an opportunity to empower through information sharing.
D4. Develop service plans together. Elicit family input regarding needs and strengths from which to build; share ideas and strategies with the family. Families should review all plans for final approval.
D5. Routinely seek supervision and feedback around maintaining honesty and transparency.
D6. Do not discuss participants in common spaces nor outside of the program during non-work hours.
D7. Do not discuss personal issues of one program participant with another program participant.
D8. Inform participants about the limits of privacy and confidentiality.

Supervisors/Managers/Agency Leaders
S1. Allocate time for input on organizational and programmatic goals.
S2. Be explicit about processes and decisions made at meetings and in between meetings.
S3. Be articulate and open in how and why decisions are made.
S4. Organize kickoff event for trauma-informed organizational transformation.
S5. Develop a parallel process of honesty and transparency through supervision; model transparent and honest communication in supervision as a mechanism to build confidence and skills in staff.
S6. Post materials on traumatic stress, its impact on individuals and trauma specific resources available to staff and participants.
S7. Provide written policies covering trauma sensitive practices, safety to staff and participants, responses to crises and professional conduct for staff and implement these across the agency.
S8. Review policies regularly with staff and participants.

7. Manage professional and personal stress.

Direct Service
D1. Practice stress awareness and recognition skills; identify and develop an array of stress reduction activities to use throughout the day – practice using and incorporating them into your work.
D2. Develop and practice self-compassion.
D3. Routinely check-in with supervisor regarding professional and personal stress. Practice seeking help and guidance.

Supervisors/Managers/Agency Leaders
S1. Allow staff to use sick days as wellness days.
S2. Promote reflective supervision. Place emphasis on relational supervision as opposed to administrative supervision. Develop agency-wide supervision structure (10 minutes administrative; 50 minutes reflective/relational).
S3. Agency leadership and management should consistently strive to move the organization to be less crisis-driven.
S4. Provide training, education and discussion regarding secondary stress. Teach staff how to recognize their stress levels and manage stress. Provide strategies and tools to effectively manage stress in a healthy manner.
S5. Actively engage staff in developing a healthier, safe, and stress-free work environment. Elicit their ideas and create a work culture of safety, self-care and self-compassion together.
S6. Adjust and develop policy and procedures to support a culture of self-care and stress management. Review case load size and other workload issues. Involve staff in the process. Allow staff to create a work environment or workspace that supports health, well-being and relaxation – use of natural light, well lit spaces, comfortable desks and chairs, clean and comfortable setting, etc.
S7. Encourage and model self-care. Normalize it. Send congruent messages (behavior matches words). Incorporate breathing, meditation, movement, stretching into agency practice – before/after staff meetings, supervision, home visits.

8. Provide a holistic approach to service delivery that incorporates a developmental or life-span perspective across the social ecology.

Direct Service
D1. Priority should be given to addressing all of the issues and concerns an individual presents, including economics, dental, mental health, and physical health.
D2. Promote and assist individuals in identifying both formal and informal support networks.
D3. Presume that every individual you work with has been exposed to abuse, violence, neglect, or other highly adverse experiences.
D4. Conduct an intake assessment that incorporates best practices for assessing various issues and concerns, including all physical and mental health past traumas.
D5. Update intake assessment to reflect ongoing work and changes with participant.
D6. Develop a transition plan with the participant for future service needs.

8. Provide a holistic approach to service delivery that incorporates a developmental or life-span perspective across the social ecology. *(Cont.)*

Supervisors/Managers/Agency Leaders
S1. Ensure trauma-informed care guiding principles are a component of work with children, individuals, families and communities in prevention and treatment delivery systems.
S2. Perform an organizational self-assessment to determine areas of strength and areas for improvement.

9. Utilize a person's strengths, choice and autonomy. Share power. Respect human rights.

Direct Service
D1. Use strength based, participant centered approaches, like motivational interviewing that prohibit confrontation and judgment and increase participant directed problem solving and cultural competence.
D2. Recognize that a significant number of individuals exposed to adverse childhood experiences do demonstrate positive post-traumatic functioning in one way or another.
D3. Understand that a number of factors from individual to contextual levels contribute to positive trajectories following ACEs. Protective person-centered factors include problem solving ability or pragmatic coping, positive worldview or future orientation, and positive emotionality or emotional stability. Protective contextual factors include positive interpersonal relationships, educational attainment, and meaningful employment. Assess and promote these factors.

Supervisors/Managers/Agency Leaders
S1. Understand how the provision of services can enhance or compromise human rights. Agencies should make decisions about how to address immigration issues, civil rights issues and privacy issues that limit risk to participants.
S2. Create participant advisory committees and/or support groups that are led by participants.
S3. Hold participant focus groups to assess the delivery of services.
S4. Integrate peer support into programming.
S5. Create a list of resources recommended and approved by program participants.
S6. Pay participants for their involvement in organizational development.
S7. Promote the use of parent-peer specialists.

10. Embrace diversity.

Direct Service
D1. Understand your individual biases so you can provide services that support participant needs and strengths without judgment or prejudice.
D2. Make all program information available in multiple languages.
D3. Understand cultural practices, beliefs, non-traditional family structures, including lesbian, gay, bisexual, and transgender (LGBT). families.

10. Embrace diversity. *(Cont.)*

Supervisors/Managers/Agency Leaders
S1. Complete a cultural competence organizational self-assessment.
S2. Evaluate and plan quality improvement related to respecting diversity in hiring, professional development and supervision, programming recruitment and delivery, evaluation and leadership.
S3. Understand your individual biases so you can support your staff needs and strengths without judgment or prejudice.
S4. Provide opportunities for staff or participants to share their cultures with each other (potlucks, culture nights, incorporating different types of art and music).
S5. Provide training on cultural practices, beliefs and non-traditional family structures, including LGBT families, and support staff in their daily work with diverse families.

11. Communicate with compassion.

Direct Service
D1. Avoid being judgmental and making suppositions about participants engaged in services.
D2. Seek to acknowledge, validate and understand by taking the time for people to be all heard and all said.
D3. Extend the benefit of the doubt in high conflict or tense situations. Assume the cause is due to an unmet need.
D4. Consider points of view and ask for help in building your own understanding.
D5. Understand that the primary goal in communicating is to improve the quality of the relationship.
D6. Manage your triggers and build relationship and healing skills in order to communicate with compassion.
D7. Use person-first language. Avoid de-humanizing language or language that implies an “us” versus “them” attitude.

Supervisors/Managers/Agency Leaders
S1. Avoid being judgmental and making suppositions about participants engaged in services and staff delivering the services.
S2. Seek to acknowledge, validate and understand by taking the time for people to be all heard and all said.
S3. Extend the benefit of the doubt in high conflict or tense situations. Assume the cause is due to an unmet need.
S4. Consider points of view and ask for help in building your own understanding.
S5. Understand that the primary goal in communicating is to improve the quality of the relationship.
S6. Manage your triggers and build relationship and healing skills in order to communicate with compassion.
S7. Use person-first language. Avoid de-humanizing language or language that implies an “us” versus “them” attitude.
S8. Create a mission statement that reflects trauma-informed care principles.

Guiding Principle	Corresponding Self-Assessment Area
1. Understand the prevalence and impact of trauma through ongoing education and training.	1. Supporting Staff Development: Training and Education AND Staff Supervision, Support and Self-Care
2. Promote effective collaboration across systems and disciplines.	1. Supporting Staff Development: Training and Education. 2. Creating a Safe and Supportive Environment: Establishing a Supportive Environment. Cultural Competence.
3. Utilize evidence-based practices and support promising practices.	1. Supporting Staff Development: Training and Education AND Staff Supervision, Support and Self-Care 2. Creating a Safe and Supportive Environment: Establishing a Supportive Environment. Safety and Crisis Planning.
4. Promote trauma screening, assessment and referrals to community resources.	3. Assessing and Planning Services: Conducting Intake Assessments AND Developing Goals and Plans AND Offering Services and Trauma-Specific Interventions.
5. Promote physical and emotional safety.	1. Supporting Staff Development: Training and Education AND Staff Supervision, Support and Self-Care. 2. Creating a Safe and Supportive Environment: Establishing a Safe Physical Environment AND Establishing a Supportive Environment. 3. Assessing and Planning Services: Conducting Intake Assessments AND Developing Goals and Plans. 5. Adapting Policies: Creating Written Policies
6. Build trust through honesty and transparency.	1. Supporting Staff Development: Staff Supervision, Support and Self-Care. 2. Creating a Safe and Supportive Environment: Establishing a Supportive Environment. 3. Assessing and Planning Services: Conducting Intake Assessments AND Developing Goals and Plans 4. Involving Consumers: Involving Current and Former Participants. 5. Adapting Policies: Creating Written Policies AND Reviewing Policies.
7. Manage professional and personal stress.	1. Supporting Staff Development: Staff Supervision, Support and Self-Care.
8. Provide a holistic approach to service delivery that incorporates a developmental or life-span perspective across the social ecology.	3. Assessing and Planning Services: Conducting Intake Assessments AND Developing Goals and Plans AND Offering Services and Trauma-Specific Interventions.

Guiding Principle Cont.	Corresponding Self-Assessment Area
9. Utilize a person's strengths, choice and autonomy. Share power. Respect human rights.	1. Supporting Staff Development: Staff Supervision, Support and Self-Care. 2. Creating a Safe and Supportive Environment: Establishing a Safe Physical Environment AND Establishing a Supportive Environment. 3. Assessing and Planning Services: Conducting Intake Assessments AND Developing Goals and Plans AND Offering Services and Trauma-Specific Interventions.4. Involving Consumers: Involving Current and Former Participants. 5. Adapting Policies: Creating Written Policies.
10. Embrace diversity.	1. Supporting Staff Development: Training and Education 2. Creating a Safe and Supportive Environment: Establishing a Supportive Environment. 3. Assessing and Planning Services: Conducting Intake Assessments. 4. Involving Consumers: Involving Current and Former Participants. 5. Adapting Policies: Creating Written Policies.
11. Communicate with compassion.	1. Supporting Staff Development: Training and Education AND Staff Supervision, Support and Self-Care 2. Creating a Safe and Supportive Environment: Establishing a Supportive Environment. 3. Assessing and Planning Services: Conducting Intake Assessments AND Developing Goals and Plans AND Offering Services and Trauma-Specific Interventions. 4. Involving Consumers: Involving Current and Former Participants.

Additional Resources

1. Adverse Childhood Experiences in Wisconsin: Findings from the 2010 Behavioral Risk Factor Survey, Children's Trust Fund & Child Abuse Prevention Fund of Children's Hospital, **www.wichildrenstrustfund.org/index.php?section=adverse-childhood**

2. Trauma Informed & Developmentally Sensitive Services for Children, The Multiplying Connections Initiative, the Health Federation of Philadelphia, **www.multiplyingconnections.org**

3. Child Trauma Academy, www.childtrauma.org

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